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#2712

September 15, 2008

Gail Weidman
Office of Long Term Care Living
Bureau of Policy and Strategic Planning
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105

RE: Regulation ID #14-514 (#2712)

Dear Ms. Weidman:

Introductory Comments

The comments outlined below, on the draft regulations for assisted living residences, as published in the Pa. Bulletin on August 9, 2008, are being submitted by LifeServices on behalf of our Company, our over 300 Pennsylvania residents, and our over 150 caregivers and support staff that live and work together in our five (5) assisted living communities located within western Pennsylvania.

LifeServices, a privately held Company owned and operated by Mr. Scott D. Allen and Mr. Timothy W. Coughlin, provide assisted living residence services in the Pa. municipalities of Erie, Titusville, Washington, Johnstown, and Altoona. Our Company began in 1994, in response to the "new assisted living" concept that erupted and swept across America, and LifeServices currently owns and operates the described Pa. assisted living communities as well as two others in the Cleveland, Ohio area. Our latest Community, Aberdeen Commons, is currently under construction in Highland Heights, Ohio.

All of us associated with LifeServices believe deeply in the concept of assisted living and its value to older adults and their families. We have advocated for years that the Commonwealth of Pennsylvania join us in embracing this alternative option in long term care that is fundamentally designed to promote each resident's independence, enhance each resident's dignity, respect each resident's privacy, and

provide each resident the maximum, possible capability at choosing how they live their life.

Our Company's formal mission is just four words: Independence, Privacy, Dignity, Choice. Yet, all aspects of our Company's operations, and each of our five assisted living communities in western Pennsylvania make every reasonably possible effort to embody the intent and spirit of those words in everything that we do for our residents.

We are delighted with the passage and enactment into law of Act 56. LifeServices views Act 56 as being near identical to our Company's approach in all aspects of what an assisted living residence can and should be for older adults, their families, and all of us as caregiving professionals in service to them.

We believe that the Pa. Legislature would be pleased to see the residential character of our Community's building design and grounds, our private apartment homes, our comfortable Commons, and, most importantly, our philosophy of service and care that is based upon, and expressed by, those four words in our Mission. As frail as many of our residents can be, we view our responsibility to our residents as, not "taking care of them", but rather, "helping them to take care of themselves."

We think, too, that the Office of Long Term Living and the Department of Public Welfare would be pleased with our assisted living communities in that most of the elements the Office and DPW seeks in an assisted living residence, as expressed by its draft regulations, and most older people who the Office views us as responsible to serve, as expressed by its Excludable Conditions, we serve now and have for any number of years. As an example, what the Office prescribes as the Informed Consent process, we have been practicing in our assisted living communities since the first day each of them opened.

Each of our Pa. Communities routinely enjoys 100% occupancy. Our residents in our Ohio Communities, within the past six months, were independently surveyed by the state regulatory agency there, and we achieved an overall 94% satisfaction rating by our residents and families as to our approach to service and care.

We should note, however, that six years ago, we intentionally closed down all plans to develop assisted living communities in Pennsylvania. LifeServices turned its expansion plans exclusively toward development in the state of Ohio. As native

Pennsylvanians, we took this action regrettably, but we did so exclusively because of the antiquated regulatory environment in Pennsylvania and all of the associated consequences that problem creates.

We also need to note, regrettably, that despite good intentions on the part of the Department of Public Welfare, our eagerness to license our Communities in Pa. as assisted living residences, and our interest in returning to assisted living development in our Commonwealth, if the proposed regulations stand as written, we most likely:

- will not seek licensure of our existing five Communities as Assisted Living Residences; and
- will not develop any more of our Communities in Pennsylvania even though there exists a substantial and growing need for our Communities and their services.

We would, however, like to point out that the manner in which these proposed regulations need to be adjusted in order to attract us, and many other providers like us, to the Pa. defined assisted living industry are possible and achievable if all stakeholders work together to find final compromise that is already "almost achieved."

LifeServices would also suggest that the primary reason that those compromises have not been achieved are primarily due to the lack of time and the lack of process by which the stakeholders can debate the remaining obstacles to a common solution.

The Pa. Legislature is to be commended. They have provided all of us, as advocates of assisted living, the law that we so desperately needed. Now, it is incumbent upon the Pa. Department of Public Welfare and the Office of Long Term Living to lead us to a common solution that will benefit all older Pennsylvanians, their families, the providers who support them in managing their care. It is important to note that the Commonwealth, too, will substantially benefit by a quality, cost effective long term care alternative and a thriving assisted living industry from which it can purchase assisted living services for Medicaid waiver eligible older adults.

LifeServices provides detailed section-by-section comments below on the proposed regulations. We also would like to reference that our Company has

utilized the comments submitted by the Pa. Health Care Association and the Pennsylvania Assisted Living Association as source documents for a number of issues and recommended language to adjust the draft regulations.

We would also like to highlight, prior to a section-by-section review, several broad issues in these draft regulations:

- The regulations, in many cases, do not conform to the statute and likewise exceed legislative intent;

- Similarly, the proposed regulations, in many instances, are not clear on requirements for the Department or providers thereby extending to the Department significant discretion at a later time. The purpose of proposed regulations is to allow the public and the regulated community to understand and participate in the rules governing them and to define clearly, now, as part of the formal regulation development process, the rules by which assisted living residences need to operate and what consumers can have in terms of specific expectations. If the process is managed well, there should be no need later for "interpretations" in the form of Licensing Measurement Instruments, when DPW provides quality assurance services;

- The requirements of 175 sq. feet for each living unit currently constructed will preclude many high quality personal care homes from becoming assisted living because they do not meet the 175 sq. foot standard, and will thus reduce access to this important care option. We suggest this requirement be 125 sq. feet that is consistent with the minimum requirement in other states;

- The requirement of 250 sq. feet for each living unit newly constructed will result in few, if any, facilities being built. We are suggesting that a minimum requirement of 150 sq. feet be adopted by regulation, which is in line with most other states. If Pennsylvania were to adopt a requirement of a minimum of 250 sq. feet, Pennsylvania would have the highest sq. foot requirement in the nation. If LifeServices were to attempt to meet the 250 square feet requirement for new residences, the additional square footage,

coupled with expansion of the Commons area to accommodate longer corridors, would add $1.2 million in additional construction costs alone, to our already $4.6 million construction costs for our current prototype. That additional cost moves the price points for our Community beyond the maximum threshold we have established for our resident monthly fees. In other words, low and middle income Pa. older people would view themselves as not able to afford it, we believe they wouldn't buy, and we would not risk that narrowing of our market in order to build;

- The proposed licensing fees are excessive and will be a significant dis-incentive for providers to become assisted living providers. The proposed fee structure would make Pennsylvania among the highest in the country and far in excess of surrounding states;

- The qualifications for Administrators, and the need for co-Administrators, would require us to release three of our most capable assisted living residence managers in the Company and would make operating costs so exorbitant we could not do so inside what we view to be maximum thresholds for our fees. There needs to be a reasonable alternative for Administrator qualifications that accommodates relevant operating experience and a need for reasonable alternatives for staff coverage when the Administrator is absent from the Community;

- The proposed requirements for informed consent agreements exceed the statutory requirements of Act 56 and likewise will discourage providers from participating in the assisted living program. It is our belief that providers of healthcare must have the flexibility to provide clinical services based on their best professional judgment. While consumer/resident input is necessary, appropriate, and should be met with maximum possible cooperation by the provider, final clinical judgment must be in the hands of the provider, assuming the consumer is to continue living in our residence, because of our fundamental duty of care;

- The proposed requirements for excludable conditions/exceptions exceed the statutory requirements of Act 56 and will also discourage providers from participating in the assisted living program. Consistent with the comments above, it is our belief that providers of healthcare must have the flexibility to provide clinical services based on their best professional judgment. While consumer/resident input is necessary and appropriate, final clinical judgment must be in the hands of a professional; and

- While aging in place is an important and achievable goal, it must be done safely and affordably. Providers cannot and should not be told or compelled to provide services beyond what they desire to do or believe that they can do safely.

Below are outlined a detailed series of comments and suggestions which, if accepted, will create a thriving assisted living industry in Pennsylvania which will be accessible to all, of material value to its consumers, attractive to its providers, and protect the interests of everyone.

As a Company with the above-described stake in the Pa. assisted living industry, we believe that we should have a chance to offer input into these essential regulations beyond this singular chance to submit written comments.

We request that the Pa. Department of Public Welfare and the Office of Long Term Living schedule public hearings, throughout the Commonwealth over the next 120 days. All stakeholders need the opportunity in their local communities to talk, present, work, and debate these draft regulations to a final conclusion.

Our Comments:

GENERAL PROVISIONS
§2800.1 Purpose

§2800.1(a)
No objection

§2800.1(b)
The proposed regulations state:

> (b) Assisted living residences are a significant long-term care alternative to allow individuals to age in place. Residents who live in assisted living residences that meet the requirements in this chapter will receive the assistance they need to age in place and develop and maintain maximum independence, self-determination and personal choice.

PROPOSED REVISION
(b) Assisted living residences provide housing and supportive services as needed, to elderly and disabled individuals and allows them to age in place and maintain their independence and exercise decision making and personal choice.

COMMENT
The regulatory standard proposed, "maintain maximum independence self-determination and personal choice" erroneously exceeds the standard established in the legislation that reads: "MAINTAIN THEIR INDEPENDENCE AND EXERCISE DECISION MAKING AND PERSONAL CHOICE".

Had the General Assembly wanted to impose such a standard of maintaining "maximum independence, self determination and personal choice," it would have done so. It reasonably decided not to adopt such an impractical standard. How do you determine, who decides and what constitutes "maximum independence"?

The Department seeks to create a licensing standard that deviates from the plain text of the statute which is impossible to apply fairly, uniformly and consistently.

§2800.2 Scope
No objection

§2800.3 Inspections and licenses

§2800.3(a)
No objection

§2800.3(b)

The proposed regulations read:

(b) Additional announced or unannounced inspections may be conducted at the Department's discretion.

PROPOSED REVISION

(b)Additional announced or unannounced inspections may be conducted by the Department upon receipt of reliable information suggesting the existence of harmful conditions at the facility.

COMMENT

The proposed regulation does not provide a standard establishing when the Department may or may not conduct an announced or unannounced inspection. By proposing a standard, the proposed revision provides consistency in the Department's use of its discretion.

The existence of a standard beyond at "random" decisions establishes clarity and consistency to the application of the regulations.

2800.4. Definitions

Although we are in agreement with the majority of the definitions in this section, we would like to highlight some areas where there are problems or potential problems.

Cognitive support service

The proposed regulations state:

Cognitive support services—

(i) Services provided to an individual who has memory impairments and other cognitive problems which significantly interfere with his ability to carry out ADLs without assistance and who requires that supervision, monitoring and programming be available 24 hours per day, 7 days per week, in order to reside safely in the setting of his choice.

PROPOSED REVISION

Cognitive support services-

(i) Services provided to an individual who has memory impairments [and] or other cognitive problems which significantly interfere with his ability to carry out ADLs without assistance and who requires that supervision, monitoring and programming be available 24 hours per day, 7 days per week, in order to reside safely in the setting of his choice.

COMMENT
The addition of "or" provides clarification and tracks the legislation.

Designated Person
COMMENT
The proposed regulation represents the Designated Person as a party selected at the discretion of the resident who is notified in emergency, a change in service, or administrative matters. **Most residents in assisted living select and value a Designated Person and use the Designated Person to make decisions on their behalf.** The definition of a Designated Person needs to be defined in such a manner that the resident may use the Designated Person to legally act on behalf of the resident on all matters related to the terms and conditions of the resident's residency as expressed in the Resident-Residence Contract should be resident choose to do so. The resident should also express that choice in the contractual agreement with the Residence and the Residence should be required to honor that choice and can legally depend upon the actions and decisions of the Designated Person.

Discharge
COMMENT
The term "discharge" is a term commonly used to describe a health care facility's decision to release a patient from a controlled, medical environment. The regulations for assisted living services need to use terminology that embodies the intent of the law and extends choice and dignity to the resident. For termination of a resident's residency, the regulations should refer to the action for what it is: "Termination of Residency".

Legal Representative
The proposed regulations state:

> *Legal representative*—An individual who holds a power of attorney, a court-appointed guardian or other person authorized to act for the resident.

PROPOSED REVISION
Legal representative—An individual who holds a power of attorney, a court-appointed guardian, or a Designated Person who is identified by the resident in the Resident-Residence Contract to legally act on behalf of the resident and within the scope of the Contract's terms and conditions.

COMMENT

We believe that adding the Designated Person, and the scope of the Designated Person's role, as outlined above, needs to be incorporated into the definition of legal representative. Finally, the ambiguous language at the end of the definition needs to be eliminated with the definition only applying to a resident's power of attorney, guardian, or designation person.

Special care designation

The proposed regulations state:

> *Special care designation*—A licensed assisted living residence or a distinct part of the residence which is specifically designated by the Department as capable of providing cognitive support services to residents with severe cognitive impairments, including dementia or Alzheimer's disease, in the least restrictive manner to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place.

COMMENT

The proposed definition, and all associated regulations related to cognitive support services, starts from a premise that an ALR is either totally exclusive to this special population, or, has a "distinct part" where this population is segregated and assigned to live. That "conventional wisdom" inappropriately stereotypes this special needs population, compromises their dignity by this designation, and limits this type of resident's choice as to the resident's living alternatives. While there certainly needs to be building features needed in the living environment to support these residents, and specialized care techniques to meet their care needs, many residents with cognitive support needs can succeed in living among all the residents of an ALR while receiving individualized support for their unique needs. The Department needs to apply the principle that "special care designation" applies to the "resident" and not "the residence". This approach requires that regulations for this unique population relate to the architectural features that contribute to their safety and quality of life, the assessment process that identifies their needs, the support plan that addresses those needs, the training requirements of the staff who support them, and their rights and needs within the Informed Consent process.

GENERAL REQUIREMENTS

§2800.11 Procedural requirements for licensure or approval of assisted living residences.

The proposed regulations state:

(a) Except for § 20.32 (relating to announced inspections), the requirements in Chapter 20 (relating to licensure or approval of facilities and agencies) apply to assisted living residences.

(b) Before a residence is initially licensed and permitted to open, operate or admit residents, it will be inspected by the Department and found to be in compliance with applicable laws and regulations including this chapter. The Department will reinspect newly licensed residences within 3 months of the date of initial licensure.

(c) After the Department determines that a residence meets the requirements for a license, the Department's issuance or renewal of a license to a residence is contingent upon receipt by the Department of the following fees based on the number of beds in the residence, as follows:
(1) A $500 license application or renewal fee.
(2) A $105 per bed fee that may be adjusted by the Department annually at a rate not to exceed the Consumer Price Index. The Department will publish a notice in the *Pennsylvania Bulletin* when the per bed fee is increased.

(d) A person, organization or program may not use the term ''assisted living'' in any name or written material, except as a licensee in accordance with this chapter. Corporate entities which own subsidiaries that are licensed as assisted living residences may not use the term ''assisted living'' in any written material to market programs that are not licensed in accordance with this chapter.

PROPOSED REVISION

(c)After the Department determines that a residence meets the requirements for a license, the Department's issuance or renewal of a

license to a residence is contingent upon receipt by the Department of the following fees based on the number of beds in the residence as follows:

(1) A $500 license application or renewal fee.

(2) A [$105] $10.00 per bed fee that may be adjusted by the Department annually at a rate not to exceed any increases in MA reimbursement. The Department shall publish a notice in the Pennsylvania Bulletin when the per bed fee is increased.

(3) No Assisted Living Residence shall be required to pay more than $1000.00 when aggregating the $500.00 license application or renewal fee in paragraph (1) and the per bed fee of paragraph (2).

COMMENT

We understand the necessity of establishing a licensing fee. However, the fees in the proposed regulations are unreasonably high and will only serve to significantly reduce, if not eliminate, and effectively quash the potential for the existence of serving the lower income MA resident.

The proposed licensure fee structure is a severe change in policy from the system that has been used by personal care homes and nursing homes, and would cause significant burden on the provider. A $500.00 licensure fee, with a $105.00 assessment per bed would result in a 100-bed facility paying an annual licensure fee of $11,000.00. Under the proposed fee structure, Pennsylvania would be more than twice as expensive as Florida (with a licensure fee of $5408.00 for a 100 bed facility), and would be five times the cost of licensure in Illinois, Ohio, Texas, and Virginia combined (Illinois being the most expensive of that group at $800.00 for a 100 bed facility).

The proposed fees are also in direct contradiction to Act 56 in that the Law states that licensing fees are to be established such that they "augment" the costs to the Commonwealth in providing quality assurance services. The proposed fee structure is organized in such a manner to fully fund the quality assurance activities of the Commonwealth for assisted living residence services.

Finally, these fees, if imposed, will only be assigned as one more cost to be assigned into the pricing of residency to residents thereby cost shifting the Commonwealth's financial responsibility to the resident that the Commonwealth is charged to protect.

The final irony of this approach is that the Commonwealth is, in fact, harming itself financially, in that, when Medicaid waivers are implemented for assisted living services, the Commonwealth will become a primary purchaser of assisted living and will be unnecessarily adding to its own costs for care.

§2800.12. Appeals

COMMENT

As proposed, providers only have opportunity at appeal as it relates to the status of their licensure as an assisted living residence. Providers of assisted living services need to have an ability to appeal citations assigned to them as well. Assisted living residences in Pennsylvania is a new alternative in long term care, that has any number of subtleties in the service delivery process that all stakeholders need to better learn and understand over time. There is a high likelihood that citations will occur despite the best efforts of all parties to act consistent with the intent of Act 56 and its associated regulations. To not create a venue and process by which citations can be debated and resolved eliminates an opportunity to evolve the industry over time in a manner to be more consistent with the Act and, most importantly, what consumers need assisted living residences to be for their quality of life. Of particular note, too, are the significant financial penalties and licensure risks imposed upon the provider based upon such citations. A provider needs a legal avenue of appeal in that regard as well.

§2800.13 Maximum capacity

No objection

§2800.14 Fire safety approval

No objection.

§2800.15 Abuse reporting covered by law.

No objection.

§2800.16 Reportable incidents and conditions.

The proposed regulations state:

(a) A reportable incident or condition includes the following:

(1) the death of a resident

(3) An injury, illness or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts.

PROPOSED REVISION

(1) the death of a resident unless the resident and the resident's care was governed by a support plan that includes hospice services;

(3) A serious bodily injury or trauma requiring treatment at a hospital or medical facility. [An injury, illness or trauma requiring treatment at a hospital or medical facility.] This does not include minor injuries such as sprains or minor cuts.

COMMENT

Although it is clearly acknowledged that certain incidents and conditions should be reported, excessive reporting requirement imposed on less significant or impactful injuries creates administrative effort which detracts from personal care and attention devoted to the residents, and will also cause an extra administrative burden on the Department. For example, some residents in assisted living facilities will certainly be on dialysis. The proposed regulation would require that every visit to a hospital for dialysis treatment would require reporting. Visits often occur 3-4 times a week.

The proposed revision utilizes the standard for personal care homes that acknowledges that all injuries are not the same. There is no reason to deviate from that standard which has worked well.

Similarly, reporting the deaths of residents who are part of a hospice process is an undue burden on the residence and DPW.

The legislature acknowledged the closeness in the regulation of personal care homes and assisted living facilities. In fact it was the intent of the legislation to allow for the inspection of dually licensed personal care home / assisted living facilities. Thus, it makes common sense to have the standard identical for personal care and assisted living.

The legislation reads as follows:
(C) The Department shall have enforcement and licensure staff dedicated solely to assisted living residences. All inspections of residences dually licensed as assisted living residences and personal care homes shall be conducted by a team of surveyors comprised of both personal care home and assisted living residence surveyors.

The 2600 regulation achieves a balance between the importance of reporting important incidents and conditions and avoiding the imposition of an unnecessary administrative burden on providers.

§2800.16 Reportable incidents and conditions

The proposed regulations state:

(a) A reportable incident or condition includes the following:

(20) An absence of staff or inadequate staff to supervise residents.

(f) The residence shall keep a copy of the report of the reportable incident or condition.

PROPOSED REVISION

(20) An absence of staff such that residents receive inadequate care as defined by the respective support plans [or inadequate staff to supervise residents].

(f) The residence shall keep a copy of the report up to 7 years after the discharge of the resident of the reportable incident or condition.

COMMENT

We assume that as worded absence of staff is a reportable incident to the extent that it impacts upon the care of residents as defined in their respective support plans. We believe the proposed language clarifies the intent of this regulation.

As worded in the proposed regulations, there is no time frame given for the retention of documents. This poses an administrative burden not adding value to the care of the residents. The retention of documents requirement for assisted living facilities should be consistent with health care facilities which is seven (7) years after the discharge of the patient or resident.

§2800.17 Confidentiality of records.

No objection

§2800.18 Applicable laws.

No objection.

§2800.19 Waivers.

No objection

§2800.20 Financial management.

No objection

§2800.21 Offsite services.
No objection

§2800.22 Application and Admission
COMMENT
Given the critical importance of the assessment and support plan development process in an assisted living environment, this process needs to be initiated during the planning and decision making stages of a resident's residency.

The proposed regulations extend a 15 day, post residency, requirement to complete a resident's assessment. How does an assisted living residence ensure that it can meet, and is meeting from the first day of residency, the care needs of a resident if an assessment has not been completed? The regulations should require that an assessment is completed by the first day of residency and no earlier than 30 days prior to initial residency. This ensures quality of care and is not an undue burden on the assisted living residence.

With that timeframe requirement assigned to the assessment process, there is no need for a pre-admission screening instrument, and this process, and associated form, needs to be eliminated.

Similarly, the regulations should require that a resident's support plan is organized and in place on the first day of residency. How does one care for a resident for the first 30 days of residency if a support plan is not in place from the time that the resident assumes residency?

Additionally, the regulations should include a formal reassessment, and adjustments in the resident's support plan as necessary, thirty days from the date of initial residency. Operating experience of assisted living residences clearly indicate that, with the best of intentions, residents, families, significant others, and the assisted living residence, itself, do not have a complete, accurate understanding of the resident's needs and preferences until at least after the first thirty days of initial residency. More severe, unknown care needs are routinely uncovered. And, with thirty days of proper medication, nutrition, hydration, and behavioral supervision, other care needs can materially be reduced. With a goal of promoting the resident's independence, dignity, and choice of how they want to have their services provided, there is a need, after thirty days, for all involved parties,

especially the resident and the Designated Person, to review and adjust the support plan.

The proposed regulations state:

> (b) Upon application for residency and prior to admission to the residence, the licensee shall provide each potential resident or potential resident's designated person with written disclosures that include:
> (3)A copy of residence rules and resident handbook. The resident handbook shall be approved by the Department.

PROPOSED REVISION

(b) Upon [application for residency and prior to admission] the submission of signed formal application to the residence, the [licensee] residence shall provide each potential resident or potential resident's designated person with written disclosures that include:

(3)A copy of residence rules and resident handbook. [The resident handbook shall be approved by the Department.[

COMMENT

We support the transparency and openness of communication that is achieved by provision of documents to a potential resident. However, the efficient administration of a business would dictate the provision of such extensive documentation be provided to a person who is seriously considering becoming a resident as opposed to someone who is considering multiple facilities.

The specific approval of the Resident Handbook, prior to use, is beyond the need for a minimum regulation to achieve the intent of the statute. The Department can certainly review the Handbook during inspection to ensure compliance with regulations as it can any number of administrative documents associated with the assisted living residence. There is no need for this burden to be imposed upon the resident, who can be unnecessarily delayed in the move in process, the assisted living residence who must obtain the approval, and the Department required to review and grant the approval.

Finally, the title of the section needs to be changed to "Application and Initial Residency". Like the earlier point made on "discharge", the word "Admission" relates to the placement of an individual in a facility at the direction of a medical professional and the concurrence of the admitting health care facility. Act 56 challenges all of us in the field of long term care to recognize that assisted living is "resident centered", not "medical professional" and "facility" directed. The resident is not "being admitted". The resident is "choosing to establish residency."

§2800.23 Activities
No objection

§2800.24 Personal Hygiene
No objection

§2800.25 Resident-residence contract

§2800.25(a)
COMMENT
The Resident-Residence Contract is the fundamental document that outlines the terms and conditions of the relationship between the two parties. The contract is usually the fundamental tool that helps the assisted living residence communicate to the resident, and their designated party, the scope of the residence's services and all associated pricing. The contract is the fundamental instrument that the resident can rely upon in understanding the terms of their residency and their expectations as to services and all associated costs. Why would a residence permit a residency without a contract in place? Why would a resident assume residency someplace without first understanding the nature, terms, and conditions associated with that residency? Completing a Resident-Residency Contract, prior to assuming residency, should be a requirement of each party associated with the contract.

§2800.25(b)
The proposed regulation states:

> (b) The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days' notice or by the residence with 30 days' notice in accordance with § 2800.228 (relating to transfer and discharge).

PROPOSED REVISION

(b) The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must [run] be month-to-month with automatic renewal unless terminated by the resident with 30 [14] days' notice or by the residence with 30 days' notice in accordance with § 2800.228 (relating to transfer and discharge).

COMMENT

The right to terminate and the notice of termination should be mutual. There is no reason, to have different standards for the residence and the resident regarding the right to terminate and the required notice of termination. Using the same standard provides clarity for both resident and residence.

§2800.25(c)

COMMENT

(2) (iii) Laundry services should not be a core service of assisted living. The assisted living residence should provide a core service of weekly linen service that includes laundering the resident's sheets and towels. Personal laundry is, first of all, "personal." The resident should have the choice of doing their personal laundry or having family do their laundry with them. And, if that is the resident's "choice", the resident should not be unduly burdened financially for having to pay for personal laundry as part of a core service.

(2) (iv) Transportation should not be a core service of assisted living. Requiring transportation services limits the resident's choice by imposing upon them what may typically be an unnecessary service and associated cost to them.

§2800.25(c)

(3) No objection

(4) No objection

(5) No objection

(6) No objection

(7) No objection

(8) No objection

(9) No objection

(10) No objection

(11) No objection

(12) No objection

(13) No objection

§2800.25(d)
No objection

§2800.25(e)
The proposed regulation states:

> (e) The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract or upon receipt of the initial support plan. The resident shall pay only for the services received. Rescission of the contract must be in writing addressed to the residence.

PROPOSED REVISION
(e) The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract [or upon receipt of the initial support plan.]. The resident shall pay only for the services received. Rescission of the contract must be in writing addressed to the residence.

COMMENT
Seventy-two (72) hours is a typical time frame in Pennsylvania within which to cancel a contract from the time of initial execution.

(f) No objection

(g) No objection

(h) No objection

§2800.25 (i)
The proposed regulation states:

> (i) The assisted living services included in the package the individual is purchasing shall be the contract price. Supplemental health care services must be packaged, contracted and priced separately from the resident residence contract. Services other than supplemental health care services must be priced separately from the service package in the resident-residence contract.

PROPOSED REVISION
(i) [The assisted living services included in the package the individual is purchasing shall be the contract price.] The resident-residence contract shall identify the assisted living services included in the package the individual is purchasing and the total price for those services. Supplemental health care services [must] shall be packaged, contracted and priced separately from the resident residence contract. [Services other than supplemental health care services must be priced separately from the service package in the resident-residence contract.]

COMMENT
The proposed regulatory language imposes a requirement beyond that which is expressed in the legislation. The legislation states that regulations for assisted living residences shall, "provide that supplemental health care services shall be packaged, contracted and priced separately from the resident agreement"

The revision we have proposed is consistent with what the legislation expresses regarding the "resident-residence" contract.

§2800.26 Quality management
No objection

§2800.27 SSI recipients.
The proposed regulations states:

> (c) The administrator or staff persons may not seek or accept any payments from funds received as retroactive awards of SSI benefits, but may seek and accept the payments only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the residence and for which full payment has not been received.

PROPOSED REVISION

(c) The administrator or staff persons may [not] seek or accept [any] payments from funds received as retroactive awards of SSI benefits, but [may seek and accept the payments] only to the extent that the retroactive awards cover periods of time during which the resident actually resided in the residence and for which full payment has not been received.

COMMENT

The requirements for the residence to deal with SSI income of the residents proposed in these regulations is different from the standards utilized in the personal care 2600 regulations.

The legislation expressly authorizes facilities to be dually licensed as personal care homes and assisted living residences. (See 8(C) of Act 56 2007). The legislators foresaw instances where personal care home residents and assisted living residents would reside in the same building.

In section 2800.20 there are multiple provisions relating to the management of resident finances. These provisions are identical to the regulations governing resident finances in personal care homes. It is important, for the sake of the resident, to provide consistency and clarity regarding all financial management issues. This would include the management of SSI benefits.

For this reason, the proposed revision is identical to the comparable section in the 2600 personal care home regulations.

§2800.28 Refunds

§2800.28(a)

No objection

§2800.28(b)

The proposed regulations state:

(b) After a resident gives notice of the intent to leave in accordance with § 2800.25(b) (relating to resident-residence contract) and if the resident moves out of the residence before the expiration of the required 14 days, the resident owes the residence the charges for rent and personal care services and supplemental health

care services, or both, for the entire length of the 14-day time period for which payment has not been made.

PROPOSED REVISION

(b) After a resident gives notice of the intent to leave in accordance with § 2800.25(b) (relating to resident-residence contract) and if the resident moves out of the residence before the expiration of the required [14] 30 days, the resident owes the residence the charges for rent and personal care services and supplemental health care services, or both, for the entire length of the [14] 30 - day time period for which payment has not been made.

COMMENT

The proposed revision makes this section consistent with 2800.25(b) that is referenced in this section.

§2800.28 Refunds

§2800.28(c) – (g)

No objection

§2800.29 Hospice care and services

No objection

§2800.30 Informed consent process.

The proposed regulations state:

(a) *Initiation of process.*

(1) When a licensee determines that a resident's decision, behavior or action creates a dangerous situation and places the resident, other residents or staff members at imminent risk of substantial harm by the resident's wish to exercise independence in directing the manner in which they receive care, the licensee may initiate an informed consent process to address the identified risk and to reach a mutually agreed-upon plan of action with the resident or the resident's designated person. The initiation of an informed consent process does not guarantee that an informed consent agreement, which is agreeable to all parties, will be reached and executed.

(2) When a resident wishes to exercise independence in directing the manner in which the resident receives care, the resident may initiate an informed consent process to modify the support plan and attempt to reach a mutually agreed upon plan of action with the licensee. A cognitively impaired resident

shall be eligible for an informed consent agreement only if the resident's legal representative is included in the negotiation of the informed consent agreement and executes the agreement.

(b) *Notification.*
(1) When the licensee chooses to initiate an informed consent process, the provider shall do so by notifying the resident and, if applicable, the resident's designated person in writing and orally. The notification must include a statement that the long-term care ombudsman is available to assist in the process and include the contact information for the ombudsman. For cognitively impaired residents, the ombudsman shall be automatically notified by the licensee. Notification shall be documented in the resident's file by the licensee.
(2) When a resident or, if applicable, the resident's legal representative chooses to initiate an informed consent negotiation, the resident or the resident's legal representative shall do so by notifying the licensee in writing or orally. Notification shall be documented in the resident's file by the licensee.

(c) *Resident's involvement.* A resident who is not cognitively impaired shall be entitled, but is not required, to involve his legal representative and physician, and any other individual the resident wants involved, to participate or assist in the discussion of the resident's wish to exercise independence and, if necessary, in developing a satisfactory informed consent agreement that balances the resident's choices and capabilities with the possibility that the choices will place the resident or other residents at risk of harm.

(d) *Informed consent meeting.*
(1) In a manner the resident can understand, the licensee shall discuss the resident's wish to exercise independence in directing the manner in which he receives care. The discussion must relate to the decision, behavior or action that places the resident or persons other than the resident in imminent risk of substantial harm and hazards inherent in the resident's action. The discussion must include reasonable alternatives, if any, for mitigating the risk, the significant benefits and disadvantages of each alternative and the most likely outcome of each alternative. In the case of a resident with a

cognitive impairment, the resident's legal representative shall participate in the discussion.

(2) A resident may not have the right to place persons other than himself at risk, but, consistent with statutory and regulatory requirements, may elect to proceed with a decision, behavior or action affecting only his own safety or health status, foregoing alternatives for mitigating the risk, after consideration of the benefits and disadvantages of the alternatives including his wish to exercise independence in directing the manner in which he receives care. The licensee shall evaluate whether the resident understands and appreciates the nature and consequences of the risk, including the significant benefits and disadvantages of each alternative considered, and then shall further ascertain whether the resident is consenting to accept or mitigate the risk with full knowledge and forethought.

(e) *Successful negotiation.* If the parties agree, the informed consent agreement shall be reduced to writing and signed by all parties, including all individuals engaged in the negotiation at the request of the resident, and shall be retained in the resident's file as part of the service plan.

(f) *Unsuccessful negotiation.* If the parties do not agree, the licensee shall notify the resident, the resident's legal representative and the individuals engaged in the informed consent negotiation at the request of the resident. The residence shall include information on the local ombudsman or the appropriate advocacy organization for assistance relating to the disposition and whether the licensee will issue a notice of discharge.

(g) *Freedom from duress.* An informed consent agreement must be voluntary and free of force, fraud, deceit, duress, coercion or undue influence, provided that a licensee retains the right to issue a notice of involuntary discharge in the event a resident's decision, behavior or action creates a dangerous situation and places persons other than the resident at imminent risk of substantial harm and, after a discussion of the risk, the resident declines alternatives to mitigate the risk.

(h) *Individualized nature.* An informed consent agreement must be unique to the resident's situation and his wish to exercise independence in directing the manner in which he receives care. The informed consent agreement shall be utilized only when a resident's decision, behavior or action creates a

situation and places the resident or persons other than the resident at imminent risk of substantial harm. A licensee may not require execution of an informed consent agreement as a standard condition of admission.

(i) *Liability*. Execution of an informed consent agreement does not constitute a waiver of liability beyond the scope of the agreement or with respect to acts of negligence or tort. An informed consent agreement does not relieve a licensee of liability for violation of statutory or regulatory requirements promulgated under this chapter nor affect enforceability of regulatory provisions including those provisions governing admission or discharge or the permissible level of care in an assisted living residence.

(j) *Change in resident's condition*. An informed consent agreement must be updated following a significant change in the resident's condition that affects the risk potential to the resident or persons other than the resident.

PROPOSED REVISION
{THE FOLLOWING PROPOSED REVISION WOULD REPLACE THE PROPOSED SECTION 2800.30}

(a) Initiation of process.

(1) When a residence determines that a resident's decisions, behavior or action creates a situation that places the resident, other residents, or staff members at risk of harm, the residence may either initiate a transfer or discharge as indicated in section 2800.228, or initiate an informed consent process to address the identified risk and attempt to reach a mutually agreed-upon plan of action with the resident or the resident's representative. The initiation of an informed consent process does not guarantee that an informed consent agreement, which is agreeable to all parties, will be reached and executed.

(2) When a resident wishes to exercise independence in directing the manner in which he/she receives care, the resident may initiate an informed consent process to address the identified deviation from the residence's care plan and attempt to reach a revised and mutually agreed-upon plan of action with the residence.

(b) Notification.

(1) When the residence chooses to initiate an informed consent negotiation, the residence shall do so by notifying the resident and, if applicable, the resident's representative in writing and orally. Notification shall be documented in the resident's file by the residence.

(2) When a resident chooses to initiate an informed consent negotiation, the resident shall do so by notifying the residence in writing and orally. Notification shall be documented in the resident's file by the residence.

(3) Residents who are diagnosed with cognitive impairment shall be eligible for an informed consent agreement only if the individual's guardian or legal representative is included in the negotiation of the informed consent agreement and signs the agreement when executed.

(c) Resident's involvement. The resident shall be entitled, but is not required, to involve his legal representative and physician, to assist in developing a satisfactory informed consent agreement.

(d) Informed consent meeting.

(1) In a manner the resident can understand, or in the case of an individual with cognitive impairments that individual's guardian or legal representative, the residence may discuss the decision, behavior or action that places the resident or persons other than the resident in potential harm, the substantial risks and hazards inherent in the resident's action, reasonable alternatives for mitigating the risk, if any, the significant benefits and disadvantages of each alternative reasonably identified and the most likely outcome of each alternative. If no acceptable alternatives exist, the negotiation shall be treated as unsuccessful.

(2) A resident shall not have the right to place persons other than themselves at risk, but, consistent with statutory and regulatory requirements, may elect to proceed in the possible development of an informed consent agreement which affects only his or her own safety or health status. At this point, the resident and residence may initiate negotiation on an informed consent agreement acceptable to all parties. During the negotiation of the informed consent agreement, the resident shall cease the actions and/or behavior that prompted the initiation of the negotiation and comport himself/herself according to the original care plan and according to all rules and policies of the residence.

(e) Successful negotiation. If the parties agree, the informed consent agreement shall be reduced to writing and signed by all parties, including individuals engaged in the negotiation, and shall be retained in the resident's file as part of the service plan.

(f) Unsuccessful negotiation. The residence retains the right not to sign an informed consent agreement if it determines that the agreement creates an unacceptable level of risk for the residence. The residence shall notify the resident and the resident's representative that agreement has not been reached, and whether the residence will issue a notice of transfer or discharge.

(g) Freedom from duress. An informed consent agreement must be voluntary and free of force, fraud, deceit, duress, coercion or undue influence. A residence may issue a notice of discharge in the event a resident's decision, behavior or action fails to mitigate the risk under discussion, and places the resident or persons other than the resident at risk of harm and, after a discussion of the risk, the resident declines alternatives to mitigate the risk, including entering into an acceptable informed consent agreement. The issuance of a notice of discharge shall not be considered as duress, coercion, force or undue influence.

(h) Individualized nature. An informed consent agreement shall be unique to the resident's situation and utilized only when a resident's decision, behavior or action creates a situation that places the resident or persons other than the residents at risk of harm. A residence shall not require execution of an informed consent agreement as a standard condition of admission.

(i) Liability. Execution of an informed consent agreement shall release the provider from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement.

(j) Change in resident's condition. An informed consent agreement must be updated following a significant change in the resident's condition that affects the risk potential to the resident or persons other than the resident, according to the process outlined above.

COMMENT

The regulatory language proposed by the Department distorts the legislative language outlined in the statute, which was developed after lengthy and thoughtful discussions.

The proposed revisions follow both the legislative intent and language in the statute and outline a process that is equitable for the resident.

The proposed regulation, as pertaining to liability, imposes the extreme pre-condition on a residence of having to determine that residents or staff are at "imminent risk of substantial harm" before it may initiate actions to address a "dangerous" situation caused by a resident. This standard, which is similar to that necessary for involuntary committal for mental health treatment, is simply unreasonable from a personal security safety perspective and liability perspective.

While a high threshold properly exists before someone may be subject to involuntary treatment, such a standard is assuredly inappropriate in the context of a residence's having to react promptly and effectively to a "dangerous" situation caused by a resident.

Our proposed revision provides the residence, which is ultimately responsible and potentially liable for actions occurring in the facility, the operational flexibility to address the presenting problem.

The proposed revision also reflects the statutory intent of the legislation as it relates to releasing the residence, "from liability for adverse outcomes resulting from actions consistent with the terms of the informed consent agreement".

The changes in the proposed revision not pertaining to liability serve to balance the rights of the residents, the residence and the residence's obligations to its other residents.

The proposed revisions support the belief that resident input is necessary and appropriate in this process, but any final clinical judgment, pertaining to the informed consent agreement, must be in the hands of the professional.

RESIDENT RIGHTS

§2800.41 Notification of rights and complaint procedures.

No objection

§2800.42 Specific rights

§2800.42(a) – (o)

No objection

§2800.42(o)

(o)The proposed regulatory language states:

> A resident has the right to freely associate, organize and communicate with his friends, family, physician, attorney and other persons.

PROPOSED REVISION

(o)A resident has the right to freely associate, organize and communicate with others privately. [his friends, family, physician, attorney and other persons.]

COMMENT

We fully support the right of the resident to freely associate; however; for purposes of consistency and uniformity, because a facility could be dually licensed, it is important that the regulations relating to the rights of a resident to freely associate be identical to each other. The proposed revision is identical to the standard for personal care homes concerning a resident's right to freely associate.

§2800.42(p)

No objection

§2800.42(q)

No objection

§2800.42(r), (s)

No objection

§2800.42(t)

(t)The proposed regulatory language states:

> (t) A resident has the right to file complaints on behalf of himself and others with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.

PROPOSED REVISION

(t) A resident has the right to file complaints [on behalf of himself and other] with any individual or agency and recommend changes in policies, residence rules and services of the residence without intimidation, retaliation or threat of discharge.

COMMENT
It is of utmost importance to create a peaceful environment for all residents without abridging the rights of the residents. The proposed revision is identical to 2600.42(t) governing personal care homes, which has proven to be a workable standard. The proposed revision promotes uniformity and consistency for both residents and residences.

§2800.42(u) - (x)
No objection

§2800.42(y)
(y)The proposed regulatory language states:

> (y) To the extent prominently displayed in the written resident-residence contract, a residence may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with health care and supplemental health care services). When the residence does not designate, the resident may choose the supplemental health care service provider.

PROPOSED REVISION
(y) To the extent prominently [displayed] disclosed in the written resident-residence contract, a residence may require residents to use providers of supplemental health care services as provided in § 2800.142 (relating to assistance with health care and supplemental health care services). When the residence does not designate [,] specific supplemental health care service providers, the resident may choose the supplemental health care service provider. The actions and procedures utilized by a supplemental health care service provider chosen by a resident must be consistent with the residence's systems for caring for residents. This includes the handling and assisting with the administration of resident's medications, and shall not conflict with Federal laws governing residents.

COMMENT
The language in the proposed regulation exceeds statutory language that was carefully and thoughtfully discussed by the legislature. It is of paramount importance to ensure the quality of care and safety of the residents that there be consistency in the handling of medications and supplemental health care

§2800.43 Prohibition against deprivation of rights
No objection

§2800.44 Complaint procedures.
No objection

STAFFING
§2800.51 Criminal history checks.
No objection

§2800.52 Staff hiring, retention and utilization
No objection

§2800.53 Qualifications and responsibilities of administrators
COMMENT
There needs to be a qualification opportunity extended to those management professionals who have substantial experience working in the field of senior care services management and who may not have all of the formal educational requirements as required by the proposed qualifications. To that end, we propose an additional criterion that is used to qualify assisted living residence administrators in the state of Ohio.
SUGGESTED LANGUAGE
The Administrator shall have one of the following qualifications:
(6) Has three thousand hours of direct operational responsibility for a senior housing facility, health care facility, residential care facility, licensed personal care home, adult care facility or any other group home licensed or approved by the state;

§2800.54 Qualifications for direct care staff persons
COMMENT
The proposed regulations require two conditions to be met by direct care staff persons: age; and a high school diploma, GED, or active registry status in the nurse aide registry. There is a contradiction in the proposed regulation that food service workers and housekeepers can be 16 years of age and older, but it does not waive the educational requirements for these persons as it waives the age minimum of 18 years.

§2800.55 Portability of staff qualifications and training
No objection

§2800.56 Administrator staffing
The proposed regulations state:

(a) The administrator shall be present in the residence an average of 40 hours or more per week, in each calendar month. At least 30 hours per month shall be during normal business hours.
(b) The administrator shall designate a staff person to supervise the residence in the administrator's absence.
The designee shall have the same training required for an administrator.

SUGGESTED LANGUAGE
(a) The administrator shall be present in the residence an average of [40]20 hours or more per week, in each calendar month. [At least 30 hours per month shall be during normal business hours.]
(b) The administrator shall designate a staff person to supervise the residence in the administrator's absence.
[The designee shall have the same training required for an administrator.] The designee shall have received training sufficient to fulfill the administrator's responsibilities in the event of the administrator's absence. [the same training required for an administrator.]

COMMENT
It is essential that all staff, including administrators, be well trained to care for residents. It is also important that administrators understand the needs of residents and be present in the facility a significant portion of their time.

The Chapter 2600 regulations impose a requirement that administrators be present in the facility for 20 hours or more a week. This standard has worked well in practice; we suggest that a similar requirement be applied to assisted living residences. It is important for an administrator to be present in the residence; however, this must be balanced with other important duties or responsibilities of an administrator. An administrator, for example, must meet his or her continuing education requirements and have the flexibility, where appropriate, to visit other residences in order to interact and learn from other administrators. The requirement in the proposed regulations of doubling the number of hours an administrator must be on site precludes administrators from fulfilling other aspects of their position.

As previously stated, the two types of entities, personal care home and assisted living units can exist in one building. Our proposed revision concerning hours presents a standard identical to the requirement in the 2600 regulations governing personal care homes. This revision creates greater administrative flexibility and provides for greater quality of life care for the residents.

§2800.57 Direct care staffing
No objection

§2800.58 Awake staff persons
No objection

§2800.59 Multiple buildings
No objection

§2800.60 Additional staffing based on the needs of the residents
§2800.60 (a) – (c)
No objection

§2800.60 (d)
The proposed regulations state:

> (d) In addition to the staffing requirements in this chapter, the residence shall have a nurse on call at all times. The on-call nurse shall be either an employee of the residence or under contract with the residence.

PROPOSED REVISION
(d) In addition to the staffing requirements in this chapter, the residence shall have a licensed nurse on call at all times. The licensed on-call nurse shall be either an employee of the residence or under contract with the residence.

COMMENT
The proposed revision clarifies that a licensed nurse should be on call at all times.

§2800.2800.61 Substitute personnel
No objection

§2800.62 List of staff persons
No objection

§2800.63 First aid, CPR and obstructed airway training

The proposed regulations state:

(a) There shall be sufficient staff trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

PROPOSED REVISION

(a) There shall be [sufficient] at least one staff person for up to 50 residents trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

COMMENT

The proposed revision is identical to 2600.63 governing personal care homes. The proposed regulation provides a specific standard which ensures the safety of the residents and provides clarity for the expectations of the residence.

§2800.64 Administrator training and orientation

§2800.64 (a) – (f) No objection

PROPOSED ADDITION

(g) A licensed nursing or personal care home residence administrator who is employed as an administrator prior to the effective date of this chapter, is exempt from the training and educational requirements of this chapter if the administrator continues to meet the applicable licensing requirements. A licensed nursing or personal care home residence administrator hired as an administrator after the effective date of this chapter, shall complete and pass the Department-approved assisted living residence administrator competency-based training test.

COMMENT

The proposed regulation does not address the situation of a licensed nursing home or personal care home residence administrator regarding training requirements.

We believe that the experience and training of licensed nursing home or personal care home residence administrator employed as such prior to the effective date of these proposed regulations warrants exemption from the above proposed

educational requirements as long as he or she continues to meet the requirements of the appropriate department of the Commonwealth.

§2800.65 Direct care staff person training and orientation
No objection

§2800.66 Staff training plan
No objection

§2800.67 Training institution registration
No objection

§2800.68 Instructor approval
No objection

§2800.69 Additional dementia-specific training
No objection

PHYSICAL SITE
§2800.81 Physical accommodations and equipment
No objection

§2800.82 Poisons
No objection

§2800.83 Temperature
COMMENT
A caution is offered in the use of the term "central air conditioning" in this section. The draft regulations require that there be individually controlled heating and cooling thermostats in the living units and we support that regulation to encourage CHOICE of temperature of the living environment for residents. However, the most cost efficient method of meeting this standard is to provide individual heating and cooling units for each apartment, either as stand alone units in a closet enclosure or "through the wall units" in each living unit's exterior wall. Requiring central air conditioning for the entire residence, and then requiring individual heating and cooling zones off of that central unit, for each living unit is so cost prohibitive, it simply can't be done. Individual heating and cooling units, as "built ins" in new construction, need to satisfy this regulation.

§2800.84 Heat sources
No objection

§2800.85 Sanitation
No objection

§2800.86 Ventilation
No objection

§2800.87 Lighting
No objection

§2800.88 Surfaces
No objection

§2800.89 Water
No objection

§2800.90 Communication system
No objection

§2800.91 Emergency telephone numbers
No objection

§2800.92 Windows and screens
No objection

§2800.93 Handrails and railings
The proposed regulations state:

(a) Each ramp, interior stairway, hallway and outside steps must have a well-secured handrail.

PROPOSED REVISION

(a) Each ramp, interior stairway, [hallway] and outside steps must have a well-secured handrail. Hallways must be secure for the mobility of residents.

COMMENT

One of the many goals of an assisted living facility is to create a home-like environment for its residents. The proposed regulation calls for a "handrail" in the

hallway. To require a formal "handrail" in the hallway detracts from a home-like setting by creating a more "institutionalized "atmosphere.

§2800.94 Landings and stairs

§2800.94(a) – (b)
No objection

§2800.94(c)
The proposed regulations state:

(c)Stairs must have strips for those with vision impairments.

PROPOSED REVISION
(c) Emergency exit [S]stairs must have strips for those with vision impairments.

COMMENT
We are concerned that those who are vision impaired are able to exit in an emergency; however, the use of strips, in non-exit areas, detracts from achieving a home-like atmosphere and institutionalizes the environment for the residents.

As stated in the comments for §2800.93(a), it is the goal of an assisted living facility to create a "home-like" atmosphere without compromising the safety of its residents.

§2800.95 Furniture and equipment
No objection

§2800.96 First aid kit
No objection

§2800.97 Elevators and stair glides
No objection

§2800.98 Indoor activity space
The proposed regulation states:

(a) The residence shall have at least two indoor wheelchair accessible common rooms for all residents for activities such as reading, recreation and

group activities. One of the common rooms shall be available for resident use at any time, provided the use does not affect or disturb others.

PROPOSED REVISION

(a) The residence shall have at least [two] one indoor wheelchair accessible common room for [all residents for] activities such as reading, recreation and group activities. The common rooms shall be available for resident use at any time, provided the use does not affect or disturb others.

COMMENT

Practically, one indoor wheelchair accessible common room is sufficient such that all of the residents can enjoy and live comfortably in the residence.
The requirement of more than one indoor wheelchair accessible room does not add to the quality of life or increase the safety of the residents. This is why the proposed revision suggests one indoor wheelchair accessible room

§2800.99 Recreation space

No objection

§2800.100 Exterior conditions

No objection

§2800.101 Resident [bedrooms] living units

The proposed regulations state:

(b)(1) For new construction of residences after (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit for a single resident must have at least 250 square feet of floor space measured wall-to-wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.

(2) For residences in existence prior to (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit must have at least 175 square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.

PROPOSED REVISIONS

(b)(1) For new construction of residences after (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit for a single resident must have at least [250] 150 square feet of floor space measured wall-to-wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit. (2) For residences in existence prior to (Editor's Note: The blank refers to the effective date of adoption of this proposed rulemaking.), each living unit must have at least [175] 125 square feet measured wall to wall, excluding bathrooms and closet space. If two residents share a living unit, there must be an additional 80 square feet in the living unit.

COMMENT

As stated in our introductory remarks, the new category of Assisted Living is an important option to the present and future elderly and disabled populations in Pennsylvania.

Unfortunately, the proposed regulation regarding the square footage requirements for living units will result in a two-tiered system of assisted living that will preclude access to facilities for only those with considerable resources to pay.

In fact the proposed regulation requirements pose a serious barrier to the construction of new assisted living facilities and the conversion of existing personal care homes to assisted living facilities. The current market rate for construction is not conducive to building or converting facilities in accordance with these requirements.

Based on the best available data today, it is clear that the overwhelmingly majority of states require 100 square feet or less for a single occupancy living unit in an assisted living facility. This statistic includes Florida, a state that also has a large existing and growing elderly population. Florida's requirement is 80 square feet.

Assessing that same data further indicates that currently only 8 states have a requirement of greater than 150 sq. feet per single living unit.

If Pennsylvania were to adopt the proposed 250 sq. feet requirement it would place Pennsylvania at the top of the sq. foot requirements nationally.

From a cost perspective, and as outlined in Appendix 1, at 250 square feet the likely charge in 2008 dollars for a unit would be approximately $4,615 a month; at 200 square feet $4,150 and at 150 square feet $3,650. These numbers change significantly for the Philadelphia area and of course do not take into account the inflation rate that would impact future construction.

We understand and appreciate the importance of residents living in comfortable home-like settings. However this important goal must be balanced with the equally important goal of effectively establishing an assisted living market that is affordable to more than those who are the wealthiest in the state.

The proposed revision presents a standard comfortable for residents and economically feasible and attainable for residences. It helps to ensure that there can and will be a strong assisted living market within the Commonwealth.

§2800.102 Bathrooms
No objection

§2800.103 Food service
No objection

§2800.104 Dining room
No objection

§2800.105 Laundry
COMMENT
Laundry service, provided at least weekly, for bed linens and towels should be a core service requirement for an assisted living residence. However, as personal laundry is a matter of reasonable PRIVACY, a resident should have the CHOICE and opportunity at INDEPENDENCE of doing one's own laundry. The residence should have the responsibility of making washers/dryers accessible within the residence for the resident's use. Laundry of the resident's personal clothing should be available to the resident as a service of the residence, at the resident's discretion. The residence should be able to charge for the additional, optional service.

§2800.106 Swimming areas
No objection

§2800.107 Emergency preparedness
No objection

§2800.108 Firearms and weapons
The proposed regulation states:

(a) A residence shall have a written policy regarding firearms.

PROPOSED REVISION
(a) A residence shall have a written policy regarding firearms where firearms are on the premises or in possession of any resident or staff member. A residence is not required to permit firearms.

COMMENT
The proposed revision gives a residence the option of not having a written policy regarding firearms if they are barred from the premises.

§2800.109 Pets
No objection

FIRE SAFETY
§2800.121 Unobstructed egress
No objection

§2800.122 Exits
No objection

§2800.123 Emergency evacuation
No objection

§2800.124 Notification of local fire officials
No objection

§2800.125 Flammable and combustible materials
No objection
§2800.126 Furnaces
No objection

§2800.127 Space heaters
No objection

§2800.128 Supplemental heating sources
No objection

§2800.129 Fireplaces
No objection

§2800.130 Smoke detectors and fire alarms
No objection

§2800.131 Fire extinguishers
The proposed regulation states:

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor and living unit, including the basement and attic.
(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen and in the living units. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

PROPOSED REVISION
(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor [and living unit,] including the basement and attic.
(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. [and in the living units.] The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

COMMENT
The safety of the residents, staff and residence from the hazards of fire is of utmost importance. However, the provision of fire extinguishers in every living unit poses the possible problem of misuse and risk of harm to self or other residents.

The National Fire Protection Association ("NFPA") recommends that a person not travel more than 75 feet to gain access to a portable fire extinguisher. NFPA also requires that only personnel who have received training use portable fire extinguishers. One reason for this requirement is that a person could use a fire extinguisher on the wrong type of fire and hurt him or herself and possibly spread the fire.

The proposed revision makes this section identical to the 2600 regulations which are consistent with what NFPA recommends, and given that many facilities will be dually licensed, makes logical sense.

§2800.132 Fire drills
No objections

§2800.133 Exit signs
No objection

RESIDENT HEALTH
§2800.141 Resident medical evaluation and health care
No objection

§2800.142 Assistance with health care and supplemental health care services
The proposed regulations state:

> (a) The residence shall assist the resident to secure medical care and supplemental health care services. To the extent prominently displayed in the written admission agreement, a residence may require residents to use providers of supplemental health care services approved or designated by the residence. If the resident has health care coverage for the supplemental health care services, the approval may not be unreasonably withheld. The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

PROPOSED REVISION
§2800.142 Assistance with health care [and supplemental health care services]
(a) The residence shall assist the resident to secure medical care. [and supplemental health care services.] To the extent prominently [displayed] disclosed in the written admission agreement, a residence may require residents to use providers of supplemental health care services approved or designated by the residence. [If the resident has health care coverage for the supplemental health care services, the approval may not be unreasonably withheld.] The residence shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

COMMENT
The proposed regulation is inconsistent with and goes beyond the text of the statute. Although a residence may assist a resident in securing medical care, by

definition in the statute and regulations, "supplemental health care services" is the provision of health care. The statutory text does not give a resident the right to select a supplemental health care provider IF the residence elects to provide or select a supplemental health care services provider. The department's regulation creates a right that does not exist in the legislation.

§2800.143 Emergency medical plan
No objection

§2800.144 Use of tobacco
No objection

NUTRITION
§2800.161 Nutritional adequacy

§2800.161(a) –(f)
No objection

§2800.161(g)
The proposed regulation states:

> (g) Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented in the resident's support plan.

PROPOSED REVISION
(g)Between-meal snacks and beverages as determined by the residence shall be available at all times [for each resident,] unless medically contraindicated as documented in the resident's support plan.
COMMENT
In order for the residence to ensure the quality and nutritional value of between meal snacks, the residence must have the ability to determine what is offered to the residents. Of course, the residents should have input into this process.

§2800.161(h)
The proposed regulation states:

> (h) Residents have the right to purchase groceries and prepare their own food in addition to the three meal plan required in § 2800.220(b) (relating to

assisted living residence services) in their living units unless it would be unsafe for them to do so consistent with their support plan.

PROPOSED REVISION

(h) Residents have the right to purchase groceries and prepare their own food in addition to the three meal plan required in § 2800.220(b) (relating to assisted living residence services) in their living units unless it would be unsafe for them to do so consistent with their support plan. Exercising this right will not substitute for or waive the resident's financial obligation for meals as part of the resident agreement core services.

COMMENT

The proposed revision of the proposed regulation is offered for purposes of clarification. Any independent purchasing of groceries for the purpose of preparing meals should not replace the initial resident agreement that includes the provision of meals.

§2800.162 Meals

§2800.162(a) –(e)

No objection

§2800.162(f)

The proposed regulations state:

> (f) A resident shall receive adequate physical assistance with eating or be provided with appropriate adaptive devices, or both, as indicated in the resident's support plan.

PROPOSED REVISION

(f) A resident shall receive adequate physical assistance with eating or be provided with appropriate adaptive devices, or both, as indicated in the resident's support plan. In the event that providing such assistance exceeds the residence's ability to meet the resident's specific health care needs, the residence has the option of terminating the residency of the resident in accordance with §2800.228. Any fees incurred in providing assistance beyond standard eating accommodations may be passed on to the resident.

COMMENT
The residence must have the ability to safely and effectively provide for and meet the resident's health care needs. Consequently the residence must have the ability to terminate a resident's residency when the needs of the resident exceed the capabilities of the residence. Likewise, if additional staffing and services are necessary beyond what is defined in the resident/residence agreement, the residence must have the ability to charge for the additional services.

§2800.162(g)
No objection

§2800.163 Personal hygiene for food service workers
No objection

§2800.164 Withholding or forcing of food prohibited
No objection

TRANSPORTATION
§2800.171 Transportation

COMMENT
Many residents who reside in an assisted living residence do not have the need for transportation services to be provided by the assisted living residence. Requiring an assisted living residence to provide the service, as part of its core services, compromises the INDEPENDENCE of residents who can manage their own transportation needs, limits the CHOICE of residents who, may or may not, want to avail themselves of such a service, and imposes unnecessary costs, and increased pricing onto the consumer by requiring the residence to provide it, generate associated costs, and assign those costs to the pricing paid by the consumer. Provision of transportation services should be at the discretion of the assisted living residence in making it part of its package of services. The scope of the transportation services should also be left to the discretion of the assisted living residence. If, in fact, the assisted living residence chooses to provide such a service, the regulations proposed regarding vehicle standards, driver standards, first aid kits, escort support, use of cell phones, is reasonable and we have no objection to them.

MEDICATIONS

§2800.181 Self-administration
No objection

§2800.182 Medication administration
No objection

§2800.183 Storage and disposal of medications and medical supplies
No objection

§2800.184 Labeling of medications
No objection

§2800.185 Accountability of medication and controlled substances
No objection

§2800.186 Prescription medications
No objection

§2800.187 Medication records
No objection

§2800.188 Medication errors
No objection

§2800.189 Adverse reaction
No objection

§2800.190 Medication administration training
No objection

§2800.191 Resident education
No objection

SAFE MANAGEMENT TECHNIQUES

§2800.201
No objection

§2800.202 Prohibitions
No objection

§2800.203 Bedside rails

§2800.203(a)
§2800.203(b)
The proposed regulations state:

(a) Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.

(b) Half-length rails are permitted only if the following conditions are met:

(1) The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

(2) The residence has attempted to use less restrictive alternatives.

(3) The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

PROPOSED REVISION

(a) [Bedside rails may not be used unless the resident can raise and lower the rails on his own.] Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.

(b) Half-length rails are permitted only if the following conditions are met:

(1) The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

(2) The residence has attempted to use less restrictive alternatives.

(3) The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

COMMENT

We support the language recommended by the Department that precludes the use of bed rails as a mechanical restraint, yet recognizes the value of half bed rails that provides residents both a safety measure and a means to promote their INDEPENDENCE by being able to re-position themselves in their own bed. We recommend that the requirement that the resident needs to be able to raise and

lower the bed rails on their own be eliminated in recognition of the same issues expressed in the earlier regulation related to the use of devices that provide support for the achievement of functional body position or proper balance. The same language used in 2800.202 (5) is applicable for bed rails as well.

SERVICES

§2800.220 Assisted living residence services

The proposed regulations state:

> (a) *Services*. The residence shall provide core services as specified in subsection (b). Other individuals or agencies may furnish services directly or under arrangements with the residence in accordance with a mutually agreed upon charge or fee between the residence, resident and other individual or agency. These other services shall be supplemental to the core services provided by the residence and shall not supplant them.
> (b) *Core services*. The residence shall, at a minimum, provide the following services:
> (1) Nutritious meals and snacks in accordance with §§ 2800.161 and 2800.162 (relating to nutritional adequacy; and meals).
> (2) Laundry services in accordance with § 2800.105 (relating to laundry).
> (3) A daily program of social and recreational activities in accordance with § 2800.221 (relating to activities program).
> (4) Assistance with performing ADLs and IADLs as indicated in the resident's assessment and support plan in accordance with §§ 2800.23 and 2800.24 (relating to activities; and personal hygiene).
> (5) Assistance with self-administration of medication or medication administration as indicated in the resident's assessment and support plan in accordance with §§ 2800.181 and 2800.182 (relating to self-administration; and medication administration).
> (6) Household services essential for the health, safety and comfort of the resident based upon the resident's needs and preferences.
> (7) Transportation in accordance with § 2800.171 (relating to transportation).
> (c) *Supplemental services*. The residence shall provide or arrange for the provision of supplemental health care services, including, but not limited to, the following:
> (1) Hospice services.
> (2) Occupational therapy.
> (3) Skilled nursing services.
> (4) Physical therapy.

(5) Behavioral health services.
(6) Home health services.
(7) Escort service to and from medical appointments if transportation is coordinated by the residence.
(d) *Cognitive support services*. The residence shall provide cognitive support services to residents who require such services, whether in a special care unit or elsewhere in the residence.

PROPOSED REVISION

(a) Services. The residence shall provide core services as specified in subsection (b). Other individuals or agencies may furnish services directly or under arrangements with the residence in accordance with a mutually agreed upon charge or fee between the residence, resident and other individual or agency. These other services shall be supplemental to the core services provided by the residence and shall not supplant them. Core services may be itemized and separated or grouped together in accordance with the policy and practice of the residence. The residence will clearly state the pricing structure in the resident agreement. Supplemental services will be itemized in accordance with the policy and practice of the residence.

COMMENT

The provision of the option of bundling or unbundling core services provides the resident the greatest flexibility in making his or her own CHOICES with regard to the core services that he or she needs or wants.

Act 56 supports the practice that core services may be itemized or unbundled. The legislation states the following regarding the admission agreement:

> (5) All residents sign a standard written admission agreement which shall include the **disclosure to each resident of the actual rent and other charges for services** provided by the personal care home or assisted living residence. (emphasis added)

We are interested in the reasonable accommodation of the resident's desires. The proposed revision creates a manner in which this can be achieved concerning services by clearly establishing what services are available, and at what fee, so the resident can make an informed CHOICE or decision.

§2800.221 Activities program
No objection

§2800.222 Community social services
No objection

2800.223 Description of services
PROPOSED REVISION
(3)(b) The residence shall develop written procedures for the delivery and management of services from [admission to discharge] initial residency to termination of residency.
COMMENT
The terms "admission" and "discharge" relate to medical facility settings and are used to describe the facility's choices and actions in regards to the patient. Assisted living residences apply a principle of resident CHOICE and the regulations should use terminology in regards to the resident CHOOSING to establish residency and terminating residency.

§2800.224 Preadmission screening
COMMENT
Any person making application to an assisted living residence needs to be provided a formal assessment of their service and care needs prior to both the resident and the residence making a decision in regards to the resident assuming residency and the residence providing opportunity for the residency. We have found, through experience, the Department's initial screening document, of no help in that decision making process. We proposed that the screening instrument, be eliminated.
The proposed regulations state:

> (b) A potential resident whose needs cannot be met by the residence shall be provided with a written decision denying their admission and provide a basis for their denial. The potential resident shall then be referred to a local appropriate assessment agency.

PROPOSED REVISION
(b) A potential resident whose needs cannot be met by the residence shall be informed by the residence of this decision (including the reason for the denial), and [be provided with a written decision denying their admission and provide a basis for their denial. The potential resident shall then] be referred to a local appropriate assessment agency.

COMMENT

The proposed revision emphasizes the importance of providing information to the potential resident and assuring that he/she is referred to a local assessment agency in an expeditious manner without excessive administrative requirements.

We believe that when a potential resident's needs cannot be met by a residence, it is of extreme importance and urgency to assist the individual in obtaining information on where his or her needs can best be met. The proposed revision addresses this need.

§2800.225 Initial and annual assessment

The proposed regulations state:

> (a) A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or licensed practical nurse, under the supervision of a registered nurse, may complete the initial assessment.

PROPOSED REVISION

(a) A resident shall have a written initial assessment that is documented on the Department's assessment form, prior to initial day of residency and no earlier than within 30 days of initial residency. The administrator or designee [licensed practical nurse, under the supervision of a registered nurse,] may complete the initial assessment. A subsequent assessment shall be completed, no sooner than after 30 days of initial residency, and no later than 60 days of initial residency to identify any changes in the health condition and/or service preferences of the resident.

COMMENT

The proposed language clarifies that the administrator of the facility has the flexibility to choose a designee. He or she may use their best judgment as to who is the appropriate employee to complete and document the initial assessment. As indicated earlier, often unknown care needs are identified within the first thirty days of residency, and care needs, at initial residency, no longer exist after proper nutrition, hydration, and medication management occurs during the first thirty days of residency.

§2800.226 Mobility criteria

No objection

§2800.227 Development of the support plan

The proposed regulation states:

> (b) A residence may use its own support plan form if it includes the same information as the Department's support plan form. A licensed practical nurse, under the supervision of a registered nurse, shall review and approve the support plan.
>
> (c) The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's support plan on a quarterly basis and modify as necessary to meet the resident's needs.

PROPOSED REVISION

(b) A residence may use its own support plan form if it includes the same information as the Department's support plan form. A licensed practical nurse [, under the supervision of a registered nurse,] shall review and approve the support plan.

(c) The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. [The residence shall review each resident's support plan on a quarterly basis and modify as necessary to meet the resident's needs.]

COMMENT

A licensed practical nurse has the requisite knowledge and expertise to review and approve a support plan without the need for supervision by a registered nurse. Although we agree that a support plan should be current, experience has demonstrated that the proposed revised requirement of revision of the support plan within 30 days upon completion of the annual assessment or upon changes in the resident's needs is more than sufficient to ensure the care and health of the resident.

§2800.228 Transfer and discharge

The proposed regulation states:

> (a) The facility shall ensure that a transfer or discharge is safe and orderly and that the transfer or discharge is appropriate to meet the resident's needs. This includes ensuring that a resident is transferred or discharged with all his medications, durable medical equipment and personal property. The

residence shall permit the resident to participate in the decision relating to the relocation.

(b) If the residence initiates a transfer or discharge of a resident, or if the legal entity chooses to close the residence, the residence shall provide a 30-day advance written notice to the resident, the resident's family or designated person and the referral agent citing the reasons for the transfer or discharge. This shall be stipulated in the resident-residence contract.

(1) The 30-day advance written notice must be written in language in which the resident understands, or performed in American Sign Language or presented orally in a language the resident understands if the resident does not speak standard English. The notice must include the following:
(i) The specific reason for the transfer or discharge.
(ii) The effective date of the transfer or discharge.
(iii) The location to which the resident will be transferred or discharged.
(iv) An explanation of the measures the resident or the resident's designated person can take if they disagree with the residence decision to transfer or discharge which includes the name, mailing address, and telephone number of the State and local long-term care ombudsman.
(2) Prior to initiating a transfer or discharge of a resident, the residence shall make reasonable accommodation for aging in place that may include services from outside providers. The residence shall demonstrate through support plan modification and documentation the attempts to resolve the reason for the transfer or discharge. The residence may not transfer or discharge a resident if the resident or his designated person arranges for the needed services. Supplemental services may be provided by the resident's family, residence staff or private duty staff as agreed to by the resident and the residence. This shall be stipulated in the resident residence contract.

(3) Practicable notice, rather than a 30-day advance written notice is required if a delay in transfer or discharge would jeopardize the health, safety or wellbeing of the resident or others in the residence, as certified by a physician or the Department. This may
occur when the resident needs psychiatric services or is abused in the residence, or the Department initiates closure of the residence.

(c) A residence shall give the Department written notice of its intent to close the residence, at least 60 days prior to the anticipated date of closing.

(d) A residence may not require a resident to leave the residence prior to 30 days following the resident's receipt of a written notice from the residence regarding the intended closure of the residence, except when the Department determines that removal of the resident at an earlier time is necessary for the protection of the health, safety and well-being of the resident.

(e) The date and reason for the transfer or discharge, and the destination of the resident, if known, shall be recorded in the resident record and tracked in a transfer and discharge tracking chart that the residence shall maintain and make available to the Department.

(f) If the legal entity chooses to voluntarily close the residence or if the Department has initiated legal action to close the residence, the Department working in conjunction with appropriate local authorities, will offer relocation assistance to the residents. Except in the case of an emergency, each resident may participate in planning the transfer, and shall have the right to choose among the available alternatives after an opportunity to visit the alternative residences. These procedures apply
even if the resident is placed in a temporary living situation.

(g) Within 30 days of the residence's closure, the legal entity shall return the license to the Department.

(h) The only grounds for transfer or discharge of a resident from a residence are for the following conditions:
(1) If a resident is a danger to himself or others and the behavior cannot be managed through interventions, services planning or informed consent agreements.

(2) If the legal entity chooses to voluntarily close the residence, or a portion of the residence.

(3) If a residence determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the residence under § 2800.229 (relating to excludable conditions; exceptions) or within the scope of licensure for a residence. In that case, the residence shall notify the resident, the resident's designated person and the local ombudsman. The residence shall provide justification for the residence's determination that

the needs of the resident cannot be met. If a resident or the resident's designated person disagrees with the residence's decision to transfer or discharge, the residence shall contact the local ombudsman. If the residence decides to proceed with the transfer or discharge, the ombudsman shall notify the Department. The Department may take any appropriate licensure action it deems necessary based upon the report of the ombudsman. In the event that there is no disagreement related to the transfer or discharge, a plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/mental retardation program or drug and alcohol program, for assistance. The administrator shall also contact the Department.

(4) If meeting the resident's needs would require a fundamental alteration in the residence's program or building site, or would create an undue financial or programmatic burden on the residence.
(5) If the resident has failed to pay after reasonable documented efforts by the residence to obtain payment.

(6) If closure of the residence is initiated by the Department.

(7) Documented, repeated violation of the residence rules.

(8) A court has ordered the transfer or discharge.

PROPOSED REVISION
{THE FOLLOWING PROPOSED REVISION WOULD REPLACE THE PROPOSED REGULATION}

PROPOSED REVISION
(a) When a residence determines that it can no longer provide services, including services as defined in 2800.220, residence shall provide a safe and orderly transfer or discharge for the resident. The resident shall be transferred or discharged with all his medications, durable medical equipment and personal property. The residence may permit the resident to participate in the decision relating to the relocation.

(b) If the residence initiates a transfer or discharge of a resident, or if the legal entity chooses to close the residence, the residence shall provide a 30-day advance written notice to the resident (except as noted in section (3) below), the resident's family or designated person or legal representative as stipulated in the resident-residence contract.

(1) The 30-day advance written notice must be written in a language and manner the resident understands, or performed in American Sign Language or presented orally in a language the resident understands if the resident does not speak standard English. The notice must include the following:

(i) The [specific] reason for the transfer or discharge.

(ii) The effective date of the transfer or discharge.

(iii) The location to which the resident will be transferred or discharged, if it is known.

(2) Prior to initiating a transfer or discharge of a resident, the residence shall make reasonable accommodation for aging in place that may include services from outside providers as defined in 2800.220 as stipulated in the resident residence contract.

(3)Notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of:

(i)Endangerment to the health, safety or well-being of others in the residence;

(ii) When a resident's medical or psychiatric needs require more immediate transfer

(iii)When a resident is abused in a residence;

(iv) When the Department initiates closure of the residence and

(v)When a resident has not resided in the facility for 30 days.

(c) A residence shall provide the Department written notice of its intent to close the residence at least 60 days prior to the anticipated date of closing.

(d) A residence may not require a resident to leave the residence prior to 30 days following the resident's receipt of a written notice from the residence regarding the intended closure of the residence, except when the Department determines that removal of the resident at an earlier time is necessary for the protection of the health, safety and well-being of the resident.

(e) The date and reason for the transfer or discharge, and the destination of the resident, if known, shall be recorded in the resident record and made available to the Department upon request.

(f) If the legal entity chooses to voluntarily close the residence or if the Department has initiated legal action to close the residence, the Department working in conjunction with appropriate local authorities, will offer relocation assistance to the residents. Except in the case of an emergency, each resident may participate in planning the transfer. These procedures apply even if the resident is placed in a temporary living situation.

(g) Within 30 days of the residence's closure, the legal entity shall return the license to the Department.

(h) The grounds for transfer or discharge of a resident from a residence include the following circumstances:

(1) If a resident is a danger to himself or others and the behavior cannot be managed through [interventions,] services per 2800.220 [planning] or informed consent agreements.

(2) If the legal entity chooses to voluntarily close the residence, or a portion of the residence.

(3) If a residence determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the residence. The residence will provide all supporting documentation regarding the discharge to the Department, upon request. If assistance with relocation is needed, the administrator may contact appropriate local agencies, such as the area agency on aging, county mental health/mental retardation program or drug and alcohol program, for assistance. The administrator may also contact the Department.

(4) If meeting the resident's needs would require a fundamental alteration in the residence's program or building site, or would create an undue financial or programmatic burden on the residence.

(5) If the resident has failed to pay the residence after reasonable documented efforts by the residence to obtain payment.

(6) If closure of the residence is initiated by the Department.

(7) Documented, repeated violation of the residence rules.

(8) A court has ordered the transfer or discharge.

COMMENT

The essential differences between the proposed regulation and the suggested revisions to the regulation are as follows:

1) Section .2800.228, throughout its several subsections, imposes unnecessary and unduly burdensome requirements on a residence before a resident can transfer or be discharged. The proposed revisions seek to provide a greater balance between the rights and interests of the resident and the residence.

2) The regulation as proposed does not allow for transfer discharges in emergency circumstances.

3) Subparagraph "h" reflects our recommendation that the grounds for transfer and discharge include but not be limited to the eight circumstances listed. There is no legitimate or compelling reason to limit the grounds for transfer and discharge of a resident. And, of course, a resident cannot be transferred or discharged for reasons that would violate otherwise applicable state and federal law.

The input of the consumer/resident is important, necessary and appropriate however, final clinical judgment must be rest in the hands of the professional who is ultimately held responsible for the care of the resident.

§2800.229 Excludable conditions; exceptions

The proposed regulations state:

> (a) *Excludable conditions*. Except as provided in subsection (b), a residence may not admit, retain or serve an individual with any of the following conditions or health care needs:
> (1) Ventilator dependency.
> (2) Stage III and IV decubiti and vascular ulcers that are not in a healing stage.
> (3) Continuous intravenous fluids.
> (4) Reportable infectious diseases, such as tuberculosis, in a communicable state that requires isolation of the individual or requires special precautions

by a caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the residence.
(5) Nasogastric tubes.
(6) Physical restraints.
(7) Continuous skilled nursing care 24 hours a day.

(b) *Exception.* The residence may submit a written request to the Department on a form provided by the Department for an exception related to any of the conditions or health care needs listed in subsection (a) or (e) to allow the residence to admit, retain or serve an individual with one of those conditions or health care needs, unless a determination is unnecessary as set forth in subsection (e).

(c) Submission, review and determination of an exception request.
(1) The administrator of the residence shall submit the exception request. The exception request must be signed and affirmed by an individual listed in subsection (d) and accompanied by a support plan that includes the residence accommodations for treating the excludable condition requiring the exception request. Proposed accommodations must conform to the provisions contained within the resident-residence contract.
(2) The Department will review the exception request in consultation with a certified registered nurse practitioner or a physician, with experience caring for the elderly and disabled in long-term living settings.
(3) The Department will respond to the exception request in writing within 5 business days of receipt.
(4) The Department may approve the exception request if the following conditions are met:
(i) The exception request is desired by the resident or applicant.
(ii) The resident or applicant will benefit from the approval of the exception request.
(iii) The residence demonstrates to the Department's satisfaction that the residence has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.
(iv) The residence demonstrates to the Department's satisfaction that any necessary supplemental health care provider has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.
(v) The residence provides a written alternate care plan that ensures the availability of staff with the skills and expertise necessary to care for the

resident's needs related to the excludable condition in the event the supplemental health care provider is unavailable.

(5) The Department will render decisions on exception requests on a case-by-case basis and not provide for facility-wide exceptions.

(d) *Certification providers.* The following persons may certify that an individual may not be admitted or retained in a residence:
(1) The administrator acting in consultation with supplemental health care providers.
(2) The individual's physician or certified registered nurse practitioner.
(3) The medical director of the residence.

(e) *Departmental exceptions.* A residence may admit, retain or serve an individual for whom a determination is made by the Department, upon the written request of the residence, that the individual's specific health care needs can be met by a provider of assisted living services or within a residence, including an individual requiring:
(1) Gastric tubes, except that a determination will not be required if the individual is capable of self-care of the gastric tube or a licensed health care professional or other qualified individual cares for the gastric tube.

(2) Tracheostomy, except that a determination will not be required if the individual is independently capable of self-care of the tracheostomy.

(3) Skilled nursing care 24 hours a day, except that a determination will not be required if the skilled nursing care is provided on a temporary or intermittent basis.

(4) A sliding scale insulin administration, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the insulin.

(5) Intermittent intravenous therapy, except that a determination will not be required if a licensed health care professional manages the therapy.

(6) Insertions, sterile irrigation and replacement of a catheter, except that a determination will not be required for routine maintenance of a urinary

catheter, if the individual is capable of self-administration or a licensed health care professional administers the catheter.

(7) Oxygen, except that a determination will not be required if the individual is capable of self-administration or a licensed health care professional or other qualified individual administers the oxygen.

(8) Inhalation therapy, except that a determination will not be required if the individual is capable of self administration or a licensed health care professional or other qualified individual administers the therapy.

(9) Other types of supplemental health care services that the administrator, acting in consultation with supplemental health care providers, determines can be provided in a safe and effective manner by the residence.

(f) *Request for exception by resident.* Nothing herein prevents an individual seeking admission to a residence
or a resident from requesting that the residence apply for an exception from the Department for a condition listed in this section for which an exception must be granted by the Department. The residence's determination on whether or not to seek such an exception shall be documented on a form supplied by the Department.

(g) *Record.* A written record of the exception request, the supporting documentation to justify the exception request and the determination related to the exception request shall be kept in the records of the residence. The information required by this subsection shall also be kept in the resident's record.

(h) *Decisions.* The residence shall record the following decisions made on the basis of this section.
(1) Admission denials.
(2) Transfer or discharge decisions that are made on the basis of this section.

PROPOSED REVISION

§ 2800.229. Excludable conditions; exceptions.

(a) Excludable conditions. Except as provided in subsection (b), a residence may not admit, retain or serve an individual with any of the following conditions or health care needs:

(1) Ventilator dependency.

(2) Stage III and IV decubiti and vascular ulcers that are not in a healing stage.

(3) Continuous intravenous fluids.

(4) Reportable infectious diseases, such as tuberculosis, in a communicable state that requires isolation of the individual or requires special precautions by a caretaker to prevent transmission of the disease unless the Department of Health directs that isolation be established within the residence.

(5) Nasogastric tubes.

(6) Physical restraints.

(7) Continuous skilled nursing care 24 hours a day.

(b) Exception. The residence may submit a written request to the Department on a form provided by the Department for an exception related to any of the conditions or health care needs listed in subsection (a) or (e) to allow the residence to admit, retain or serve an individual with one of those conditions or health care needs, unless a determination is unnecessary as set forth in subsection (e).

(c) Submission, review and determination of an exception request.

(1) The administrator of the residence shall submit the exception request. The exception request must be signed and affirmed by an individual listed in subsection (d) and accompanied by a support plan which includes the residence accommodations for treating the excludable condition requiring the exception request. All [P]proposed accommodations must conform with the provisions contained within the resident-residence contract.

(2) The Department shall have a CRNP or a physician with a minimum of 5 years of experience in caring for the elderly and disabled in long term living settings review and respond to the exception request. [will review the exception request in consultation with a certified registered nurse practitioner or a physician, with experience caring for the elderly and disabled in long-term living settings.]

(3) The Department will respond to the exception request in writing within [5 business days] 48 hours of receipt.

(4) The Department [may] will approve the exception request if the following conditions are met:

(i) The exception request is [desired] requested by the residence and the resident [or applicant].

[(ii) The resident or applicant will benefit from the approval of the exception request.]
(ii)The submitted exception request ensures that the residence has the staff, skills and expertise necessary to care for the resident in order to accommodate the exception request.
[(iii) The residence demonstrates to the Department's satisfaction that the residence has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.]

(iii)In the event a supplemental service provider, per the agreement between the resident and residence and the supplemental service provider and that is documented in the support plan, is required to provide the necessary care, the supplemental service provider must have the necessary staff and demonstrate the appropriate expertise to care for the excludable condition. [(iv)The residence demonstrates to the Department's satisfaction that any necessary supplemental health care provider has the staff, skills and expertise necessary to care for the resident's needs related to the excludable condition.]

(iv) the submitted exception request includes a written alternate care plan if the supplemental health care provider is unavailable that ensures the availability of the necessary staff, with skills and expertise necessary to care for the resident to accommodate the excludable condition. [(v) The residence provides a written alternate care plan that ensures the availability of staff with the skills and expertise necessary to care for the resident's needs related to the excludable condition in the event the supplemental health care provider is unavailable.]

[(5) The Department will render decisions on exception requests on a case-by-case basis and not provide for facility-wide exceptions.]

Weidman-Jones, Gail

From: Timothy Coughlin, LifeServices Management President [timc@walsdc.com]
Sent: Monday, September 15, 2008 7:38 PM
To: Weidman-Jones, Gail
Subject: Draft Assisted Living Regulation Comments

Dear Ms. Weidman,

Attached is our Company's comments on the ALR proposed regulations.

We can appreciate how hard your office worked on them because we have just completed countless hours trying to fully encompass all of our best thinking to make these regulations and this initiative succeed.

We have fed-exed you a hard copy of the attachment, but we wanted to be sure that we were filed prior to the close of the deadline today.

Thank you, Gail, for assisting us in receipt of our comments.

Tim Coughlin
Owner
LifeServices